Welcome to Northwoods Family Eyecare!

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	Nickname:
Home Address:		City, ST Zip:	
Phone: (check preferred) O Home: O Cell: O Work: *I consent to receiving appointment reminders and clinic communications via text message at my cell # (please initial)*:			
Email Address:	DOB:	Sex: O M O F	Marital Status: O Single O Married O Other:
LAST FOUR SS#:	Employer/School:	Occupation/Grade:	
Billing Address (if different):			
How did you hear about our office? O Website O Insurance Plan O Referred by: O Other:			
Parent(s)/Guardian(s) if patient is a minor:	Other family members seen at this office:		
Primary Care Physician:	Practice Name and Phone #:		
Previous Eye Doctor:	Practice Name and Phone # (to obtain CL RX or records of medical condition):		
Race: O Asian O Black/African American O Pacific Islander O Native American/Alaskan O White O Decline			
Ethnicity: O Not Hispanic or Latino O Hispanic or Latino O Decline	Preferred Language: O English O Spanish O Other:		

INSURANCE INFORMATION

Please note:

Most vision plans (e.g. VSP) only cover refractions and routine, nonmedical eye exams. Visits involving medical problems such as conjunctivitis, dry eye, ocular injuries, cataracts, glaucoma, macular degeneration, sudden pain or vision loss or monitoring for ocular side effects of chronic diseases such as diabetes and hypertension fall under your medical insurance coverage, NOT your vision plan. Some Well Vision Plans will apply your benefits toward medical co-pay and deductibles and some do not. If you have any questions about your coverage, be sure to contact your insurance company before your scheduled appointment.

Medical Insurance Carrier:	ID#	Policy/Group#	
IF THE PATIENT IS NOT THE INSURED, PLEASE FILL OUT THE FOLLOWING INFORMATION FOR THE INSURED:			
Name:	DOB:	SS #: (LAST FOUR ONLY)	Patient's relation to insured: O Spouse O Child O Other
Address (if different):		Phone:	
Vision Plan:	ID#	Policy/Group#	
IF THE PATIENT IS NOT THE INSURED, PLEASE FILL OUT THE FOLLOWING INFORMATION FOR THE INSURED:			
Name:	DOB:	SS #: (LAST FOUR ONLY)	Patient's relation to insured: O Spouse O Child O Other
Address (if different):		Phone:	